

# What a critical care nursing curriculum does not teach us



Caring for a person facing death is not an easy undertaking – but it is a privilege. It has been pointed out in the literature that nurses' anxiety in caring for the dying is strongly related to fear of their own death.<sup>1</sup> Cumulative nursing experience has not been found to be a significant factor in dealing with such a fear. In fact, there are indications that the opposite holds true; uneasiness associated with interaction with the dying has increased with nursing experience.<sup>2</sup>

How can critical care nurse educators assist students to face death-related fears before they come to work in intensive care units? Thanatology (death education) has evolved through various caregiver and theological programmes since the 1970s. Early studies of death education in the nursing curricula were descriptive and used subjective evaluation to measure their effects on the student. Nursing schools in the UK spend on average between 6 and 14 hours on death education, using predominantly traditional (didactic) methods.<sup>3</sup> From my experience in nursing education, no more than a 16-hour workshop is included in postgraduate curricula in nursing education institutions in South Africa.

Critical care nurses want to ensure that dying patients experience a dignified death (maintaining personal comfort and control as the end of life approaches). Unfortunately, such deaths are not always possible in the ICU. Many deaths have been less than ideal because of inherent difficulties with the ICU environment (which is designed to save lives), and the lack of sufficient and quality time for critical care nurses to care for dying patients and the patients' families. Other problems included communication between intensivists, especially pseudo-intensivists. End-of-life care can be improved if communication measures ensure that all members of the multidisciplinary team are working towards the same goals for the patients and their families. The current literature suggests that if treatment for some dying patients is stopped earlier (or never started, especially if futile), and if intensivists are helped to understand that death is a natural process and not a direct reflection of failure of their skills or care,<sup>4</sup> less stress will be experienced by all those involved in this trying period.<sup>4</sup>

Critical care nurses feel frustration about prolonging a patient's inevitable death as well as not carrying out patients' and families' requests. This results in moral distress.<sup>4</sup>

Walter *et al.*<sup>5</sup> found that registrars, registered intensivists and critical care nurses differed in their

perception of the appropriateness of levels of care (from providing comfort to very aggressive). Walter *et al.* also found evidence that treatments should not be implemented when information indicates that a patient would not want them. This restraint in implementing treatments is especially crucial when the treatments will probably be futile.<sup>5</sup>

There are several other obstacles and barriers to providing a good death in the ICU, including staffing problems and a shortage of nurses that contribute to lack of time to care for dying patients appropriately. Other barriers and obstacles are communication challenges, including unrealistic expectations of patients' families, inappropriate treatment decisions, and some aspects of intensivists' behaviour, namely being less than truthful and/or unrealistic about a patient's prognosis.<sup>4</sup>

Educational programmes need to be developed and curricula designed to educate critical care nurses about the practicalities of providing quality end-of-life care. Nurse educators may need to be creative in order to guide curricular changes. While nurses play a major role in end-of-life care, they still have very limited participation in the end-of-life decision making.

As I have often indicated, it is of the utmost importance to improve and augment the visibility and credibility of nursing. Providing a good and dignified death in the ICU will help the patients, their families, and the moral responsiveness of nurses themselves.

*'The awareness that the dying person will soon meet God for all eternity should impel his or her relatives, loved ones, the medical, health care and religious personnel, to help him or her in this decisive phase of life, with concern that pays attention to every aspect of existence including the spiritual ...'* (Pope John Paul II).<sup>6</sup>

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